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FEBRUARY, 1915

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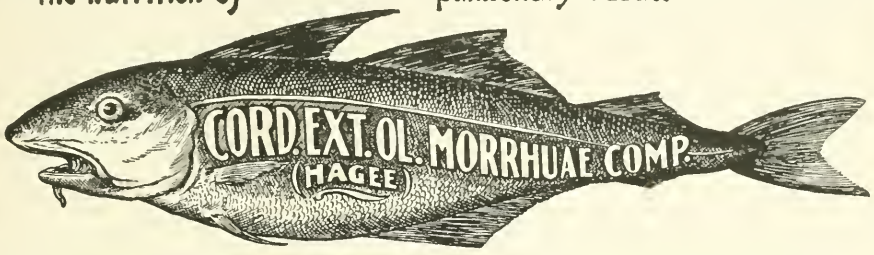

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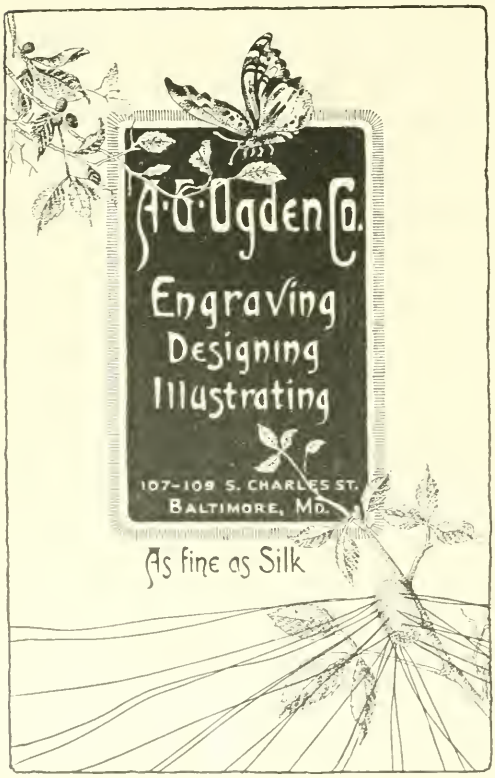

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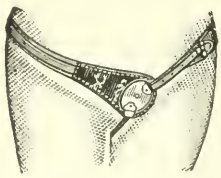

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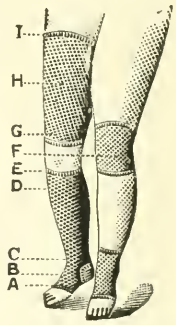

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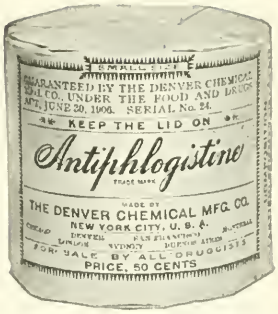
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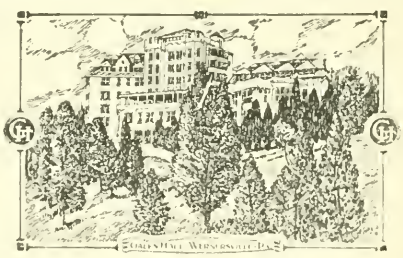

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SYSTEMIC INFECTIONS FOR WHICH THE TONSIL IS HELD RESPONSIBLE AND CONTROL OF HEMORRHAGE DURING TONSILLECTOMY.*

By M. M. Savage, M.D.,
Baltimore, Md.

I MUST begin with an apology for presenting a paper on a subject about which so much has been said and written within the last few years. But the fact that in 1912 there were 37,000 recommendations made in Philadelphia by school inspectors to parents that their children had hypertrophied tonsils and that these organs should receive immediate attention, and that in New York city in the same year 30 per cent. of 825,000 examined by the medical inspectors were thus afflicted, and since on such common ailment there is a difference of opinion, even among the specialists, as to the mode of procedure, I take courage to add another paper to the many that have been written lately, taking the stand that we owe to humanity, as well as to ourselves, to know exactly how we stand on the tonsil question.

The tonsils consist of the lymphoid masses, held together by trabeculae of fibrous connective tissue, which divide and subdivide the tonsillar tissue. The free or faucial surface is covered by mucous membrane of the mouth, which is stratified and similar to the epithelium of the surrounding tissues; the same epithelium also covers the major part of the crypts, but becomes modified early in life when the lymphoid activity is at its height. The crypts are tubular depressions, some of which run horizontally, some vertically upward into the supratonsillar fossa, and a few run downward and are covered by the plica triangularis. Of these crypts there are altogether about 15; they are irregular, some forming pockets and containing besides cellular debris, food particles and various pathogenic micro-organisms. The

*Read at the meeting of the Baltimore City Medical Society, December 18, 1914

parenchynea of v. tonsil is made up of germinating follicles and the interfollicular tissue.

The supratonsillar fossa is the space between the superior pole of the tonsil and the superior angle of the sinus. Each tonsil lies in a recess called the sinus tonsillaris, or tonsillar fossa, on either side of the fauces formed by the palatal arches. Anteriorly, it is bounded by the anterior faucial pillar (palato glossus) and posteriorly by the posterior pillar (palato pharyngeus muscle). On the other side it is attached by a fibrous membrane to the capsule which surrounds the tonsils except on its interior and exposed surface. From this membrane the fibrous trabeculæ divide the tonsils into lobes.

There are two types of tonsils: the pedunculated tonsil, sometimes mistakenly called hypertrophied tonsil, which is attached by a small base to a shallow sinus, and the whole tonsil is exposed and appears prominent. The second is the buried tonsil, or the submerged tonsil, which has a broad base and which does not extend beyond the plane of the pillars. They are often deceiving, as they may be considerable size, which is only apparent during an operation by pulling them inward with a vulselleum, or when the patient gags. Moreover, it is with this type of tonsil that is frequently the seat of disease.

We find a number of lymphocytes advancing toward the crypts and separating the epithelial layers. A number of follicles surround the crypts where there are dense masses of lymphocytes and lymphoblasts, or mother cells, which show mitotic figures; polymorphonuclear cells are also in abundance and a few plasma cells.

The function of the germinating follicles is the production of lymphoid cells which are probably the mother cells of the leucocytic group. G. B. Wood also believes that the interfollicular tissue is the pathway through which the lymphoid cells gain access to the efferent lymphatics, and that there is a direct change of the epithelial cells of the crypt into lymphoid cells.

Blood Supply.—The tonsils are very vascular, receiving their blood supply from the tonsillar and palatine branches of the facial, from the descending palatine branches of the internal maxillary, from the dorsalis linguas and from the ascending pharyngeal. Either the descending palatine or the ascending branches give rise to copious hemorrhage during a tonsillectomy.

Veins.—The veins of the tonsils form a plexus in the walls of the sinus. The largest of the plexus is seen upon removal of the tonsil superficially in the tonsillar fossa.

Davis, who has done considerable research work on the anatomy of the tonsils, claims that the arterial branches do not at all perforate the wall of the fossa, nor do they eventually reach the tonsil itself. Thus the tonsillar artery anastomoses with a branch from the dorsalis lingua and supplies the plica triangularis and the muscles entering into the formation of the wall of the lower half or two-thirds of the tonsillar fossa. The tonsillar branch of the

ascending pharyngeal sends twigs into the upper part of the wall of tonsillar fossa, but, like the tonsillar artery, they do not pass through the muscular fibers, through the capsule and into the tonsil itself. Thus there remain two arteries, the ascending palatine branch of the facial and the descending palatine branch of the internal maxillary from which by anastomosis outside the fossa a single artery is formed that enters the fossa at its superior extremity, passes downward between the capsule and the muscular aponeurosis for a distance of about half an inch before penetrating the capsule to reach the tonsil.

Lymphatics.—While no afferent lymphatics leading to the tonsils have been shown, experiment would indicate their presence. Lexer injected inert coloring matter into the turbinates and found them later in the tonsils. Henkl found the coloring matter in the tonsil after injecting it in the gums. Frenkel has called attention to the frequency with which auto infections in the nose are followed by tonsillitis.

The efferent lymphatics play an important role as portals of entry to general infections. According to Wood, they pass through the fibrous trabeculae and the capsule, pierce the superior constrictor muscle of the pharynx and empty into the tonsillar gland, one of the superior deep cervical nodes lying under the anterior border of the sterno-cleido mastoid muscle. The anterior chain of the deep cervical glands lying just under the anterior border of the sterno-mastoid receive their afferents from the tonsil at the base of the tongue, from the submaxillary and submental nodes. Grober's experiments on animals showed that the supraclavicular glands form the connecting link between the upper deeper cervical nodes and the apical pleura, and that inflammatory adhesions may extend the infection to the apices themselves. Wood states that the supraclavicular group only rarely receive afferents from the upper cervical glands, the afferents of which gradually converge and form the jugular trunk, which empties into the subclavian vein at its junction with the internal jugular. According to the same authority, tubercular infection may reach the apices, either by the supraclavicular route or occasionally through an inconstant gland of the upper anterior group which is sometimes found in the notch formed by the junction of the internal jugular and subclavian veins, and it is very closely placed to the parietal pleura of the apex. In view of the frequency with which primary tuberculosis of the tonsils occurs, the existence of this possible line of invasion between them and the lungs assumes a clinical importance. That this mode of pulmonary infection is frequent, however, is doubtful.

Functions.—As to the functions, there are two factions—those who attribute to this organ so many important functions or few of such great importance that they would prohibit the removal of the tonsils almost under any circumstances. The opposite faction, on the other hand, claim that the tonsil is a worthless organ and place it in the same class with the appendix; that the only good it does is

to give revenue to the throat surgeon. The matter of fact is that the truth lies somewhere between the two extreme opinions.

The hemopoietic theory that the tonsil is a blood-forming organ rests on a sound basis. Stoehr first discovered the constant migration of lymphocites from the interior of the tonsil to the periphery. Stoehr's phenomenon. It has also been shown that the leucocytes originate in the germinating centers of the follicles.

Some observers claim that the tonsil has a function of internal secretion (Massini) similar to the adrenals, but it is disclaimed by other investigators. Protection theory. Much has been written about the protective function of the tonsil, constituting, as it were, the first line of defense against microbic invasion similar to the functions of other lymph glands in the body, attacking and arresting pathogenic bacteria. Moreover, it is claimed that in the protective function the tonsils are aided by the phagocytic action of the lymphocytes.

A great deal has also been claimed that the tonsils protect the body against bacterial invasion (Galland, Goerke and Brieger), a quality in common with the lymphatic glands of the body. The migration of cells toward the oral cavity per se is claimed to have a strong protective influence against bacterial invasion. The protective work is further augmented by the large number of polymorphonuclear leucocytes, which make their way from the blood vessels to the surface of the tonsils.

The Immunity Theory.—Some, again, would make us believe that the tonsils, with their crypts, constantly containing large numbers of pathologic organisms, protect the body from a general infection by a process of auto-vaccination.

The tonsil is also credited with acting as a lubricant in moistening the bolus of food.

Of these theories, the first mentioned, that a tonsil is a blood-making organ, only deserves recognition, since the other theories rest merely on speculation. The functions of the tonsil, per se, as an organ of protection against microbic invasion, if it has any at all, it must be insignificant, for the upper respiratory organs are well protected. According to Ballenger, these functions are performed by the—

a. Bactericidal properties of mucous secretions.
b. The epithelial covering of the mucous membrane.
c. The lymphatic tissue composing the tonsillar ring.
d. The cervical lymphatic glands.
e. The bronchial lymphatic glands.
f. The endothelial lining of the blood and lymph vessels.
g. The serum of the circulating blood.
h. The leucocytes.

I will repeat here the words of Harry A. Barnes, who recently wrote a book on the tonsils: "From the clinical standpoint the function of the tonsil has its most important application to the question of operative procedure, whether a partial or complete removal is to be recommended when symptoms demand operative

interference. The advocates of tonsillotomy have ever had visions of the possible loss of some unknown function indispensable to the individual, which would inevitably follow the removal of the tonsils. In spite of the fact that, of the countless number of tonsilectomies done during the last few years, not one has been shown to have had any untoward result that could be attributed to the loss of any possible functionating power; in spite of the fact that the histologic structure of the tonsils show plain that their function, whatever it may be, is identical with that of the other lymphoid nodules of the body, and therefore one that would no more be missed in its removal than the function of a small area of skin would be missed. In spite of all this, the old inadequate tonsillotomy, or worse still, galvano cautery application to the crypts, are still done by many men because of a phantom function of the tonsil. On the other hand, the idea that the tonsil has no function has led in many quarters to the condemning of all tonsils that show their heads, so to speak, beyond the faucial pillars, even when no symptoms are present. It is difficult to say which attitude is productive of the more mischief. On the one hand, many patients are allowed to suffer the ill-effects of chronic toxic absorption or of recurring acute inflammatory conditions, when a simple enucleation is all that is necessary to give them complete relief, while, on the other hand, perhaps a much larger number of patients are put through a needless operation which a more careful study of the individual case might obviate. The tonsils should by all means be respected as a functionating organ, especially in children, and should never be removed without adequate cause. But when such case exists, the loss of the functionating power should not be used as an argument against their complete extirpation." Jos. C. Beck, J. A. M. A., November 7, 1914, concludes his paper of "Chronic Local Infection of the Nose, Throat, Mouth and Ear" by stating: "From my own experience, I am sure I have done very little, if any, harm by the removal of the tonsils and adenoids, and I am sure that I have done considerable good."

As it is not the intention of the essayist to treat the pathology of the tonsil, I shall but briefly mention the pathologic organisms frequently found in this organ and the systemic diseases for which they are responsible.

That bacterial flora should find an ideal field in the tonsils is self-evident on account of the anatomical peculiarities of the crypts, which are deep, tortuous and constantly contain cellular debris, food particles and having poor drainage. Several strains of streptococci are found in the crypts, even in the healthy tonsil, and of the two varieties found, the streptococcus hemolyticus is prevailing and is responsible for deep abscesses and joint lesions, and the streptococcus viridans, next in frequency, a surface growth, are supposed to be responsible for attacks of endocarditis. The streptococcus epidemicus has been found in the tonsil during epidemics of septic tonsillitis, which we had here in Baltimore three years ago. Dr. Bordley of our city has done some research work

on the tonsil from the standpoint of bacteriology, and I will quote from his report of 1910: "Culture from tonsillar crypts of 31 patients from the ages of 17 hours up to 70 years, all were infected. Staphylococci were present in all of them, 20 of which showed no signs of disease; the other 10 were atrophic; they also showed other pathological organisms, like streptococci and some pneumococci. Inoculations with bullion cultures from crypts into rats and guinea pigs were carried out to determine whether recovered organisms had undergone any special change which made them less dangerous than organisms ordinarily found in the mouth. Control cultures grown from the saliva of the same individual and from the saliva of patients whose tonsils had been completely removed were also used. In all, 14 animals, with a total of 20 inoculations, were employed. The one striking point in these experiments was the non-virulency of all the cultures. The only animals to die were those inoculated with cultures grown from the crypts of tonsils that were clearly diseased, those with cysts, hyperkeratosis and advanced atrophy. There seemed to be no relationship between the virulence of organisms in the tonsillar crypts and those in the saliva, as shown by the fact that even in the cases where death resulted from injections of cultures from diseased tonsils, cultures grown from the saliva of the same individual proved harmless. The behavior of cultures in the same medium with and without tonsillar tissue properly prepared was the same, nor was there any difference in the result of inoculations, showing that the tonsil does not, either through secretion resulting from interstitial changes or through some bactericidal power exhibited by the crypt epithelium, inhibit the action of bacteria."

Drs. Smith, Barrett and Middleton, in their paper, "Endameba buccalis" (J. A. M. A., November 14, 1914), have shown in their researches in the pathological laboratory of the University of Pennsylvania that the parasitic amebas of the mouth hold an important relation in the etiology of pyorrhea alveolaris, and that by the use of emetin as an amebacide these organisms may be destroyed and the pyorrheal lesions cured. They have also shown that these parasites frequently involve the tonsils and cause local and probable systemic infections, judging from the fact that not only the local symptoms, but also the general complications, such as anemias and joint lesions, promptly cleared up by the administration of emetin hydrochloride. It looks as if their work might lead to important discoveries. Attacks of follicular tonsillitis are usually brought about by auto-infection, due to lowered resistance.

Primary tuberculosis in the tonsil has been found in about 61 per cent. examined, and Dieulofoy, by injecting tonsillar material into animals succeeded in producing tuberculosis in 8 of 61 cases (12 per cent.). Straussman examined the tonsils from 21 cases of tuberculous cadavers and found tubercular tonsils in 13.

The Relation of Tonsils to Systemic Infections.—Among the general infections for which the tonsil is held responsible are chronic arthritis, endocarditis, pericorditis, chorea, acute and

chronic nephritis, neuritis, osteomylitis, appendicitis, peritonitis, cerival adenitis and chronic toximias. What medical practitioner has not seen rheumatic arthritis and endocarditis following attacks of tonsillitis, and who has not seen improvement or cessation of attacks of joint conditions following the removal of the tonsils? I am engaged just now to do a tonsillectomy on a young man who had a severe attack of nephritis, following a mild case of tonsollitis about a year ago, and a repetition of the same trouble following another attack of tonsillitis a month ago. About two years ago an intimate friend of mine lost his only daughter, 13 years, from endocarditis following a mild attack of tonsillitis, which amounted just to a little soreness of the throat. About four years ago I saw a girl, aged 16, who had an attack of tonsillitis followed two days later by classical symptoms of appendicitis. A year prior to this she had exactly the same experience. Pediatrists and neurologists will tell you how often cures of chorea follow the removal of the tonsils.

SYSTEMIC INFECTIONS.

In 1910 Loeb (acute nephritis following acute tonsillitis read before the Am. Lar. Rhin. and Otol. Soc.) said: "Acute nephritis results from acute tonsillitis far oftener than is generally believed."

D. J. Davis (Chr. Streptococcic Arthritis, J. A. M. A., September 6, 1913) reported the result of his observation of 42 cases of chronic streptococcic arthritis. In all of these cases the source of infection was in diseased tonsils.

F. Theisen (Albany Med. Onn., 1913) reported six cases of acute thyroiditis following tonsillitis.

Dr. Ben Witt Key (Opthalm. Record, June, 1914) speaks of absorption from tonsillar infection as a causative agent in phlyctenular conjunctivitis.

Norton L. Wilson, in *J. A. M. A.*, November, 1914, reports four cases of nephritis and four cases of rheumatic fever following typical attacks of tonsillitis. In six of these cases the tonsils were removed and prompt cures followed. One nephritis case died of acute septic endocarditis.

Dr. Bordley, in his article, "Arthritis Associated with Infection of the Nose and Throat," recently read at the convention of the Southern Medical Association, reports 32 cases of (a) arthritis deformans, 8 of which were apparently cured, 6 benefited, 12 somewhat benefited but later relapsed and 6 unimproved. Of the 8 cured cases, all had the tonsils removed, besides the sinus exenterations. One showed no improvement until after tonsillectomy. (b) Chronic arthritis with acute exacerbations. He reports 40 cases of a total of 82. In 12 of the 19 cures no benefit was recorded until after the tonsils were removed. (c) Acute rheumatic fever. Reports on 112 cases, with 79 cures. In every successful case the operation performed was tonsillectomy. In 16 diseased conditions were discovered in the nose and carefully eradicated without result on the joints, which subsequent tonsillectomy brought complete relief. In the 79 cases reported as cured, 61 had previous to the primary

rheumatic attack been operated upon, in 61 clipping tonsillectomies, and in 34 cauterization of the tonsils.

Then we often see chronic toxemias of tonsillar origin. The patient suffers from general malaise, is easily fatigued, often anemic and poorly nourished, is under weight, and presents gastro-intestinal symptoms, coated tongue and the fetor oris of the atrophic tonsil with which every one of us is familiar. The proof that the tonsil is responsible is the fact of its presence and the improvement of the general condition of the patient following the removal of the offending organ.

What laryngologist has not seen acute and chronic ear conditions caused and kept up by large or diseased tonsils? Not alone will suppurative ear and nose conditions often be cured by removal of tonsils, but a suppuration quite distant from the tonsils, as, for instance, in the bladder or uterus, will markedly improve or be cured by raising the resistance of the patient. (J. C. Beck.)

I will even not attempt to quote pages of reports of general infections of tonsillar origin, as whole books could be written on this subject alone. I shall briefly enumerate the indications for tonsillectomies.

In the first place, whenever you have large adenoids, with even small tonsils, when they show some evidence of disease.

2. Recurrent attacks of tonsillitis or peritonsillar abscess.

3. Hypertrophied tonsils when they are large enough to cause improper oxygenation.

4. In ear complications.

5. In impairment of voice and speech.

6. Systemic infections, like arthritis, endocarditis, chorea, nephritis, etc.

7. Chronic coughs, bronchial affections and interference of general development of the child.

8. Enlarged cervical glands.

Tonsillotomy is an operation of the past. The only possible excuse for the tome is simple hypertrophy. As a matter of fact, nose and throat specialists have disregarded it entirely in favor of complete enucleation in capsule.

The operation, however, has fallen into disrepute, and I can give three reasons for it: 1. The tonsil has often been removed when there were no indications, either due to mistake in judgment or as a matter of revenue, and this very fact brought about the publications of articles like "The Massacre of the Tonsils," by Dr. Mackenzie of this city, about two years ago, and "The Use and Abuse of the Tonsils," by Dr. Comroe, in the *Jour. of the A. M. A.*, October 17, 1914. 2. Either tonsils regenerate after their supposed removal, or the symptoms for which the enucleation has been done return. 3. The danger of the operation.

In answer to the first argument against operation, I would say that there must be clear indications for a tonsillectomy before it is undertaken, and these indications I have already enumerated. It is no use wasting words on a charlatan who will remove tonsils

for revenue only, as we unfortunately find the same type among general surgeons who will do an appendectomy for the same reason. There can be no recurrence of local symptoms like tonsillitis or peritonsillar abscesses or a return of systemic conditions when the tonsil was completely enucleated in the capsule.

About the dangers of the operation I will admit that it is a major operation, and in the hands of the careless and inexperienced it may assume dangerous proportions. Therefore, this operation should not be done by a general practitioner and one who has had no experience along this line. Moreover, it should not be attempted by one who cannot cope with the emergencies arising during the operation, the chief of which is hemorrhage. Unfortunately, general practitioners without surgical training and previous experience in throat surgery will often undertake a tonsil operation, whereas they would not dare undertake any other major operation, and they are the very ones to meet with emergencies, and, not being able to cope with them, bring discredit on this operation. A number of fatalities from hemorrhage have been reported, and many more have failed to reach publicity. We have had several deaths from this source in Baltimore within the past few years, and each case was well advertised throughout the city and not so soon forgotten. And this is not surprising, if you bear in mind that the causes for which patients are subjected to this operation are not always a matter of life and death, at least not so in the eyes of the friends and relatives, and the shock to them is greater should death follow an operation of this nature than it would be in cases of other major surgical operations.

I wish to report to you in brief what other authorities have to say on the question of hemorrhage. Vincent Dabney (Candidates Thesis, American Laryngological Association), *Annals of Otology and Laryngology*, says that although he never had or saw a fatal hemorrhage following an operation on the tonsils, he has been profoundly alarmed at several of his own cases, and has seen cases that resisted the skill and dexterity of experienced operators. He further remarks: "The sinister and disconcerting fact is, in my mind, that patients have died from this cause." A colleague told him of a fatal case in a girl of 15 from steady oozing until she was exsanguinated. E. A. Crockett (*Boston Medical and Surgical Journal*, March, 23, 1911) says that he considered hemorrhage a serious matter; that in one year and a half 12 deaths from hemorrhage have been reported in and about Boston, and that he believes that many more have not been reported. In addition to the 12 deaths, he recalls many serious hemorrhages, one requiring ligature of the common carotid after the scissors enucleation, and two deaths in two minutes following a sharp dissection with the scalpel. Lindley Sewell (*Medical Chronicle*, Manchester, July, 1911) was able to find reports of 19 deaths and 50 severe hemorrhages, which were controlled. Pfingst (*J. O. Laryngoscope*, July, 1911) observed a hematoma in the pharynx as a result of suturing the pillars over a pledget of gauze to control a hemorrhage which began

eight hours after the operation. Stucky reports a death from exsanguination a few hours after the operation, and nine cases of secondary hemorrhage which required a second anesthesia and ligation and suturing the pillars.

Now a few words on the obsolete recommendations of some men to control bleeding in tonsillar operations. For instance, Gerhard Hutchinson Cocks (*Medical Record*, June, 1912) on "Tonsillar Hemorrhage: Cause, Prevention and Treatment," states: "Post-operative bleeding is often stopped by slapping the face vigorously with a towel wrung out in icewater for a few minutes immediately after the operation. The bleeding usually stops after the appliance of a Miculicz or Hurd tonsillar hemostat, or if the bleeding point cannot be found, after pressure of a sponge saturated with gallic or tannic acid for a few minutes. If these measures fail, the author uses Michel's metal clamps, after filling the tonsillar fossa with gauze wet with gallis or tannic acid or powdered thrombokinase."

Howard Dutrow (*Laryngoscope*, May, 1912) is more progressive: "To control hemorrhage, use some hemostatic agent, such as a strong solution of silver nitrate, adrenalin, etc., together with pressure and ice cap to each side of the neck. Seize the bleeding points with artery forceps and tie if these measures fail."

It is more strange that the up-to-date textbooks on the nose and throat recommend these antiquated methods, and advise the tying of blood vessels as a last resort prior to ligation of the external carotid when the hemorrhage becomes serious or alarming.

The best articles I have come across in my search of literature on this subject are, one by Dr. Lee Cohen of our city, which was written four years ago, and who, by the way, was the first to advocate the ligation of bleeding vessels in a tonsil operation, to my knowledge, and a recent article by Dr. Davis in the *Laryngoscope*, March, 1914. I shall quote freely from the last article. He states: "No tonsil can be enucleated by any method without the severing of certain blood vessels, and any severed vessel affords always a possible source of hemorrhage. Those authors who state that 'if' bleeding points can be seen they may be seized, etc., have erred in the admission of the 'if,' for I believe that with the rarest exceptions definite sources of all hemorrhage can be localized and effectually controlled. It was the localizing of this fixed source of all severe hemorrhage that led me to abandon the pillar suturing process for the simpler and safer technic. It matters not, however, where the vessel be severed at its entrance into the fossa, at its capsular penetration or at any intervening point, the process of hemorrhage control is the same, namely, grasp the artery at its entrance into the superior extremity of the fossa, pass a suture ligature of No. 1 catgut underneath it and tie."

Among the other dangers of the operation is anesthesia, whether general or local. The operation should, therefore, be performed in a hospital where a trained anesthetist and skilled assistants are available. The object of a tonsillectomy, no matter by what

method, should be a complete enucleation of the tonsil, attended with the least possible bruising of the tissue, leaving the pillars and the tonsillar fossa intact, with the least consummation of time, and last, but not least, with as little loss of blood as possible. I will briefly describe a tonsillectomy as it is performed at the Hebrew Hospital of this city. The patient is admitted to the hospital early in the morning, after a light breakfast at home. A physical examination is made by one of the residents, and if no contraindication is found he is prepared for the operation, which usually takes place in the afternoon. The chief of my department, including myself, prefer to give the patient a hypo. of atropin about half an hour before the operation, as it has a tendency to check the secretion of mucus and it is also a respiratory stimulant. The patient is put in a recumbent position, with the head slightly lowered. Ether is administered by the anesthetist, first in the ordinary way, and as soon as the patient is asleep the ether is continued by a specially devised apparatus by Dr. Davis of this city. The ether passes through a hot container and is vaporized through a canula in the mouth-gag by foot bellows. By this method the anesthesia goes on and the operator is not interfered with. Another advantage of this apparatus is that it has self-retaining tongue depressors of three different sizes, and therefore permits the assistant the use of both of his hands for other purposes. An electric head lamp is used for illumination. The tonsil is injected in three different places with a solution of 16 minums of adrenolin in normal salts, which has a tendency to check oozing and to distend the sinus, bringing the tonsil out. After grasping the tonsil with a vulsellum, it is pulled forward and inward with a sickle-shaped knife, superficial incisions are made through the mucous membrane of the margo supratonsillaris, auter. pillar and through the plica. The pillars are liberated thoroughly by dull, and, if necessary, by sharp dissection, and the operation is either completed by dissection or, as I myself prefer, by the snare method. In using the snare, care must be taken that the bite of the vulsellum includes the whole tonsil before the application of the snare. The operation is facilitated by the assistant retracting the pillars and sponging when necessary. As soon as a tonsil is removed one or two firm sponges are applied with gentle pressure by means of Kelly clamps to check temporarily the bleeding. One by one of the sponges is removed, the bleeding points seized by hemostat specially devised for that purpose by Jackson of Pittsburgh, which has broad rounded ends. We make a lateral bite, leaving one end of the forceps free; the assistant holds the forceps while the operator with a piece of catgut No. 2, about 18 inches long, loosely ties a single loop about the shank of the hemostat, below the assistant's hand, and pushes it down with the index finger over the free edge of the clamp; one free end of the catgut is held between the last fingers pressed against the palm of the hand, while the index finger keeps the loop down so as to prevent the slipping off of the catgut up the shank. The other free end of the catgut is pulled tight with the other hand

until the knot is tied. The hemostat is removed by the assistant, the tie is completed by another knot and the catgut cut off. Other bleeders are similarly treated. Troublesome bleeding often occurs in the supratonsillar sinus, and the best way to get at it is to evert the pillar with a Kelly clamp. Care is to be taken not to clamp the bleeding point by doing so, as it will arrest the bleeding temporarily, but will recur as soon as the clamp is removed.

Dr. Rosenheim, of the Hebrew Hospital staff, devised a clamp which carries the loop over the bleeding point and facilitates ligation. It is surprising how easily bleeding points can be caught and ligated after a little practice, and there is no excuse for omitting its use on account of imaginary difficulty and resorting to suturing the pillars, using the clumsy, unscientific Miculicz instrument or merely to pressure by gauze sponges until the hemorrhage has apparently ceased to recur after the patient has left the operating table, and then call it, improperly, secondary hemorrhage. Since this method of ligation—the only surgical method—was adopted at the Hebrew Hospital, and the chief credit belongs to Dr. Lee Cohn, we never had a case of so-called secondary hemorrhage, and the amount of loss of blood during the operation is practically not over two teaspoonfuls.

Other throat surgeons have adopted ligation, never to give it up. As to the queston of hemorrhage in general, operators differ. Some say that this complication gives them but little trouble; others maintain that it causes them great anxiety. As a matter of fact, the fatal issues after tonsillectomies were usually due to hemorrhage. Often the surgeon finds consolation, ascribing the cause of hemorrhage to hemophilia, when as a matter of fact the "hemophilia" would have been promptly cured by one or more ligatures. Taking even for granted that you do not find spurting vessels in every case, but the reduction of the amount of blood lost in every tonsillectomy, which is from one to two ounces to one to two drams, is, *per se*, an indication for ligation, for even an ounce of blood means a great deal to a young and debilitated child. Why this method of ligation is not universally adopted by men doing tonsil operations I cannot understand. I should like to see the abdominal surgeon who would content himself to check bleeding by mere pressure with gauze sponges, sew up the abdomen and trust to the good Lord that nothing will happen to the patient?

To return to the operation which I began to describe above, I will conclude by stating that the adenoids, if present, are removed in the usual way, and a hard, firm sponge, the adenoid sponge, is pressed into the epipharynx with a Kelly clamp and kept there several minutes. The usual after-treatment consists in ice application; the patient is kept over night and discharged the next morning.

Local anesthesia is preferred in a child over 14 years of age and not of nervous temperament. A hypo. of morphine and atropin is given half an hour before the operation. My method is as follows: The points of injection at and near the pillars of the tonsils are

touched up with a 10 per cent. cocaine solution, also the pharynx; then a mixture of 8 minims of adrenolin in 1 dram of 0.50 per cent. of novocain is injected into the pillars. Blanching of the tissues is noticed almost immediately. Thereupon 0.50 per cent. of novocain is freely injected at the points of the first injection. The operation is fairly painless and the danger of cocaine eliminated, since novocain is about seven times less toxic. The tying of bleeders under local anesthesia is facilitated by lowering the back of the chair and putting the patient in a semi-prone position.

1729 Madison avenue.

A CASE OF MYXEDEMA, TREATED FOR THREE YEARS AS NEPHRITIS.*

By *Wm. T. Watson, M.D.*

About two years ago I was called to a new patient who was suffering with bronchitis. I was told by her daughter that she had had Bright's disease for three years. She looked the part. Finding her urine normal, I looked at my patient more closely and, upon my second visit, discovered that I had a typical case of myxedema.

Her age was 64.

She had not been herself for six years. Three years before I saw her her physician told the family that she had Bright's disease. He attended her over a period of two years, during which time she steadily became worse. During his absence from the city another physician saw her and treated her for nephritis. Her physician died, and inasmuch as treatment had been ineffectual, no other physician had been called in for nearly a year, when I was called to attend her for an intercurrent affection.

Upon investigation here is the condition I found:

Mind.—Her mental processes were slow.

She thought slowly, talked slowly, walked slowly.

Was always tired and sleepy. Would fall asleep whenever she sat down.

She had not been away from the block in which she resided for two years because she just thought she couldn't.

Her memory was poor; could not remember at night the happenings of the morning.

Had delusions of seeing flocks of cats, rats and dogs in her house, yard and street.

Was very suspicious. Often had headache.

Tinnitus complained of.

Skin.—Her skin was sallow and dry. She had not perspired for two years.

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*Read at Semi-annual Meeting of Medical and Chirurgical Faculty, Upper Marlboro, October 29, 1914.

Flat warts and naevi were numerous on her body.

Conspicuous soft pads were present above the clavicles.

The abdomen was large and pendulous.

Her hair had become thin and she had become bald around the margins of the hairy scalp, the so-called "frontal band alopecia." Her eyebrows were thin; her eyelashes gone. The hair on the vulva, previously profuse, was entirely absent.

Her eyelids were thick and heavy; the palpebral aperture narrowed. The eyebrows were elevated.

Her lower lip was thick and everted.

Hands and feet were enlarged, and she could not wear either gloves or shoes which she did a few years before.

Her gait was bad; often stumbled.

The tongue was enlarged; the sense of taste impaired—food did not taste good.

Heart sounds were normal. Pulse 112, regular. Blood pressure 175. Urine negative for albumin and sugar. Weight 125 pounds.

EFFECT OF TREATMENT.

She was photographed and then put upon thyroid extract, grains 2 three times a day. The effect was magical.

One week later she had lost 6¾ pounds in weight. Had not seen any cats, rats or dogs after taking the first dose. Drowsiness was leaving; memory improving. She talked more and faster. Her expression was brighter. Swelling of eyelids had diminished. Could put on her old gloves again.

In a month she had lost 12½ pounds. Her mental activity was normal. She had begun to perspire. Her pulse was down to 96 and blood pressure to 120.

In six weeks new hair began to appear upon the bald margin of the scalp. Weight was 108—a loss of 17½ pounds.

Thyroid extract was reduced to grains 2 once daily, and has been kept at that ever since. For a short period it was discontinued; she soon became tired and drowsy.

PRESENT CONDITION.

After two years. Age 66.

She has not a complaint of any kind. Is bright and cheery. Quick in speech and action. Memory excellent. Goes to church and market by herself. Does all her household work, including washing and ironing, and is proud of the fact that she can outdo many of the younger people. Never stumbles.

Her weight, which had fallen from 125½ to 106, has returned to 122. This doubtless represents the substitution of normal fat for myxedematous tissue, and very differently distributed. Her waist line has fallen from 42 to 29 inches.

All swellings are gone. The mucous membrane of nose has become thinned and she breathes more freely. The former bald

1. Photograph taken at beginning of treatment, showing dull expression, everted lower lip, prominent supraclavicular myxedematous pads and baldness at the margin of hairy scalp.

2. Photograph after two years of treatment, showing alert expression, absence of supraclavicular pads and complete return of hair.

3. Photograph taken at beginning of treatment, showing baldness at margin of hairy scalp.

4. Photograph after two years of treatment, showing a 12-inch growth of black hair on previous bald area.

places on her head are covered by hair 12 inches long. Her brows have become thick and her eyelashes have returned.

Her pulse is 72. Blood pressure 170.

ASTHMA.

At the age of 50, for the first time in her life, she had an attack of asthma. These increased in frequency and severity for several years, but were gradually subsiding. Since taking thyroid has had but one very slight attack. From a description of these attacks I doubt if they were true asthma; more likely laryngismus stridulus. Dr. Carey Gamble, from some observations he has made, believes that asthma may be a symptom of myxedema.

DIAGNOSIS.

Inasmuch as the effect of treatment is so prompt as to be almost miraculous, it is only fair to our patients that we give them the benefit of the earliest possible diagnosis.

I am glad that Dr. Beck will tell us of the atypical cases and early diagnosis.

As my patient was diagnosed as a case of nephritis, I will quote a few words about the differential diagnosis:

Anders says: "Myxedema could hardly be mistaken for acute or chronic nephritis in the absence of pitting, etc., as some have supposed."

Dock says: "Cases are still mistaken for nephritis or jaundice."

Osler says: "The general aspect of the patient—the subcutaneous swelling and the pallor—suggest Bright's disease, which may be strengthened by the discovery of tube casts and of albumin in the urine."

"But the solid character of the swelling, the exceeding dryness of the skin, the yellowish-white color, the low temperature, the loss of hair, and the dull, listless mental state should suffice to differentiate the two conditions."

CONCLUSION.

This patient, under a wrong diagnosis, was practically robbed of several years of useful life.

Correct diagnosis and treatment immediately restored her to health and usefulness.

As it is an insidious disease with sometimes one group of symptoms arising first in one case and a different group in another, it is manifestly difficult to diagnose a case in its incipiency. The case which I have reported was so typical when seen by me as not to be mistaken. Doubtless there was a time a year or two or three back when I still could have made the diagnosis, and a time still further back when one who had seen many atypical cases and was alert to the possibilities could have diagnosed it.

These full-fledged cases of myxedema are rare, yet it is possible that more of them may be found relegated to helpless invalidism under a wrong diagnosis. If so, I hope that some of you may discover them and enjoy the great pleasure that I have had in watching this individual, who had been thrown upon the scrap heap, speedily restored to a happy and useful life.

Summary of Results of Examination Held by the Board of Medical Examiners of Maryland, December 8, 9, 10 and 11, 1914.

No.	College of Graduation.	Anatomy.	Surgery.	Pathology.	Obstetrics.	Practice.	Chemistry.	Materia Medica.	Therapeutics.	Physiology.	Total.	Average.
1	University of Maryland, '14	68	89	69	90	65	68	86	78	84	697	77
2	College Physicians and Surgs., Balto., '14	87	97	71	89	81	75	83	94	82	759	84
3	Howard Medical, '14	67	90	75	80	75	70	58	64	65	644	72
4	College Physicians and Surgs., Balto., '14	Failed to appear.										
5	College Physicians and Surgs., Balto., '14	77	..	60	..	69	69	77	81	78	...	..
6	Maryland Medical College, '13	Failed to appear.										
7	Medical College of Virginia, '14	60	96	58	80	62	67	77	82	70	652	72
8	University of Maryland, '14	75	..	84	88	..	97	..	..	88	...	..
9	College Physicians and Surgs., Balto., '12	75	85	70	81	69	75	81	81	85	702	78
10	University of Pennsylvania, '13	85	94	81	79	76	79	75	89	97	755	84
11	University of Maryland, '14	81	92	85	95	81	95	86	88	75	778	86
12	College Physicians and Surgs., Balto., '14	Failed to appear.										
13	University of Maryland, '14	87	91	80	89	75	94	81	70	80	750	83
14	College Physicians and Surgs., Balto., '14	66	95	60	91	77	84	66	81	76	696	77
15	College Physicians and Surgs., Balto., '14	93	92	86	87	75	99	87	80	86	785	87
16	Maryland Medical College, '12	..	..	..	75	..	..	..	75	75	...	..
17	University of Maryland, '14	66	98	89	82	75	80	82	85	83	740	82
18	University of Maryland, '14	78	94	81	93	87	100	75	76	86	770	86
19	Maryland Medical College, '12	75	..	..	79	..	..	..	83	75	...	..
20	Maryland Medical College, '13	19	..	45	..	75	38	59	70	40	...	..
21	Johns Hopkins, '15	65	89	77	78	76	67	69	80	75	676	75
22	Johns Hopkins, '14	68	91	81	65	75	93	82	82	84	721	80
23	Johns Hopkins, '13	83	98	81	88	79	90	82	75	77	753	84
24	Johns Hopkins, '13	87	92	91	90	83	100	81	100	78	802	89
25	Maryland Medical College, '13	..	..	54	..	..	..	90	..	..	...	..
26	University of Maryland, '14	83	91	84	97	75	100	87	79	80	776	86
27	Baltimore Medical College, '13	75	..	..	..	..	75	..	..	76	...	..
28	Jefferson Medical College, '14	91	92	90	90	76	100	95	85	89	808	90
29	College Physicians and Surgs., Balto., '13	Failed to appear.										
30	College Physicians and Surgs., Balto., '13	80	88	73	75	63	65	72	82	78	676	75
31	University of Louisville, '12	42	..	..	89	75	64	76	..	80	...	..
32	University of Maryland, '14	65	97	87	92	81	76	57	77	44	676	75
33	University of Maryland, '14	Failed to appear.										
34	College Physicians and Surgs., Balto., '14	75	84	68	82	75	61	86	81	88	700	78
35	Bennett Medical, Chicago, '14	55	60	45	66	56	25	78	78	75	538	60
36	Maryland Medical College, '12	57	75	60	..	66	..	..	..	..	...	..
37	University of Maryland, '14	75	..	..	..	..	..	79	79	87	...	..
38	Maryland Medical College, '12	..	..	..	..	..	50	62	..	66	...	..
39	University of Pennsylvania, '00	82	90	88	78	80	99	88	84	85	774	86
40	University of Maryland	75	..	..	..	..	75	75	..	81	...	..
41	University of Maryland, '14	82	89	85	68	76	84	82	85	85	736	82

In the above summary an average of 75 is required of those participating in the examination for the first time in order to secure a license. Those who have failed are eligible to re-examination at the expiration of six months. They are then obliged to receive a rating of 75 in each branch in which they are re-examined before license can be issued. Under the Maryland laws, students who, at the end of their second year, have successfully passed their college examination in anatomy, Chemistry, Materia Medica and Physiology are entitled to examination by the Board of Medical Examiners in these branches. The ratings made by these students in the examination known as the "second-year examination" are carried forward and made part of the final examination, when an average of 75 must be obtained to secure a license. We trust that this statement will make clear the apparently incomplete examination of certain participants.

REPORT OF BOARD OF MEDICAL EXAMINERS OF MARYLAND.

QUESTIONS AT THE DECEMBER (1914) EXAMINATIONS.

SURGERY.

1. Give the causes of acute intestinal obstruction, with symptoms.
2. Give the differential diagnosis between malignant and non-malignant tumors of the breast.
3. Give causes, symptoms and signs of retention of urine.
4. (a) Name the inflammatory diseases of the bones. (b) Give the symptoms and treatment of one.
5. Give the symptoms and treatment of tuberculosis of the knee joint.
6. Give the differential diagnosis between a fracture of the surgical neck of the humerus and a dislocation of the shoulder joint.
7. Name the surgical affections of the testicle and describe one.
8. Give symptoms, diagnosis and treatment of glaucoma.
9. Give signs and symptoms of hydronephrosis.
10. Give the diagnostic characteristics of—(a) varicose, (b) tubercular, (c) luetic ulcer.

OBSTRETRICS.

1. Describe the placental circulation.
2. What is your treatment for placenta previa about the eighth month of pregnancy.
3. What indications require the use of forceps? Give your method of using them and the danger of their use to mother and child.
4. Describe the causes of and treatment for post-partum hemorrhage.
5. How would you treat a case of puerperal eclampsia?
6. Give some of the most frequent causes of dystocia, and differentiate between uterine inertia and obstructed labor.
7. How would you manage a posterior shoulder presentation.
8. Name two of the most frequent growths of the uterus. Describe their formation and method of removal.
9. Give the various dimensions of the pelvis and describe what presentations are best adapted to them.
10. Give the diagnosis of pregnancy of the third month.

PRACTICE.

1. Definitions: Define (a) Grocco's sign. (b) Graves' disease. (c) Landry's paralysis. (d) Uremia. (e) Enteroptosis.
2. (a) Name the day of eruption in smallpox, chicken-pox, measles and scarlet fever. (b) State the duration of infection in each disease.
3. (a) Name the varieties of chronic nephritis. (b) Give symptoms and treatment of one variety.
4. Differentiate coma of alcohol, uremia and cerebral hemorrhage.
5. Name types of dysentery. Give treatment of one type.
6. Give causes of ascites and indicate how to recognize by what disease it is produced.
7. Give treatment of acne vulgaris.
8. Name types and give treatment of influenza.
9. Give treatment of acute cystitis.
10. Give treatment of erysipelas.

PATHOLOGY.

1. Describe the local and systemic morbid processes of diphtheria.
2. Define (a) Hematoma. (b) Ecchymosis. (c) Infarct. (d) Phlebolith. (e) Phlebitis. (f) Cholelithiasis.
3. Describe the differences between lobar and broncho-pneumonia.
4. Mention five diseases that are known to be transmitted by insects, naming the carrier and describing the method of transmission in each case.
5. Describe the prophylaxis of hydrophobia and state its theory.
6. Describe the processes terminating in dry gangrene.
7. Describe the gross and microscopic appearance of an amyloid kidney. Mention an antecedent condition and the urinary changes.
8. Describe the formation of intestinal adhesions.
9. Describe the method of isolating and recognizing bacteria.
10. How would you prepare a specimen of tissue for microscopic examination?

PHYSIOLOGY.

1. Describe the physiology of the portal circulation.
2. (a) Give composition, reaction, uses and specific gravity of the blood and the causes of the variations in specific gravity. (b) State why the blood remains fluid in the body and coagulates when shed.
3. Define tidal, complemental, reserve and residual air, and respiratory capacity.
4. In nutrition of the body what is the method of comparison of income and output of material?
5. Describe the glands and villi of the intestines and state what digestive changes take place in the small and in the large intestines.
6. Urine—the composition, specific gravity, reaction and average quantity passed in 24

hours. State also the most frequent abnormal ingredients of the urine.

7. Describe the process of absorption and state how the digested food enters the circulation.

8. What are the functions of the bile, the ingredients and how secreted.

9. (a) What is the normal temperature of the body, how regulated and sustained? (b) What are some of the conditions affecting the body temperature.

10. (a) What is meant by voluntary and involuntary muscles? Give examples. (b) Define tonic and clonic muscular contraction. Give examples of each.

MATERIA MEDICA.

1. (a) Define tincture, fluid extract, decoction and infusion. (b) What is the ordinary relative strength of a tincture to a fluid extract of the same drug.

2. Name the ingredients of compound chalk powder, compound licorice powder, carron oil, of the official compound cathartic pill and compound spirits of lavender.

3. Name three each of circulatory stimulants, circulatory depressants, antispasmodics, emetics, carminatives and diuretics. Give average dose of each.

4. Give the average adult dose of the following, using the official terms: Tincture nux vomica, tincture opium, Fowler's solution of arsenic, sulph. of atropia, sulph. strychnine, tincture veratrum (Norwood's) and tincture of digitalis.

5. Name and describe methods of introducing medicines into the circulation.

6. Mention three evils that might result from chemical incompatibility, and state the difference between an antagonist and an antidote.

7. Give the official preparations and doses of antimony, antipyrin, apomorphin, silver, aspirin, atropin, and use official terms.

8. (a) What are antitoxins? Name three and give source from which derived. (b) Give average adult dose of each and state how administered.

9. Name five official preparations each of iron and ammonium and give doses.

10. Define and describe alkaloids. Name three official alkaloids and give their doses. Define solvent and mention three.

THERAPEUTICS.

1. Write a prescription in Latin, without abbreviation (with "Fowler's solution" as one of the ingredients), stating condition for which used.

2. Write a compound prescription for an adult suffering with insomnia.

3. What drugs modify arterial tension? Give indications for their use.

4. Name two drugs which accelerate the action of the heart and likewise two which retard action; give dose of some official preparation of each.

5. Describe symptoms and treatment of acute arsenical poisoning.

6. Give the therapy of carbolic acid; symptoms of poisoning and treatment.

7. Name three counter-irritants. Give therapy of action, indications for their use and best methods of application.

8. Give your views as to the value of tuberculin therapy, theory of action and mode of administration.

9. Give the therapy of thyroid, indications and contraindications for its use, and mode of administration.

10. Name the "bromides." Give the differences in their action, and state why the common mixture of potassium and bromide and hydrate chloral is sometimes unsafe.

ANATOMY.

1. Describe the diaphragm, including openings, nerve supply, action and relations.

2. Name and describe briefly the varieties of epithelium, stating where each variety is found.

3. Describe the fibula. With what bones does it articulate? What muscles are attached to it?

4. Name branches of abdominal aorta.

5. What muscles or tendons cross knee joint? Which of them are extensors?

6. Origin and distribution of ophthalmic nerve.

7. Name all structures severed by amputation through middle of leg.

8. What nerves supply the tongue?

9. Locate deltoid, glenoid and Poupart's ligaments.

10. What passes through Hunter's canal?

CHEMISTRY.

1. Define normal salt, acid salt, basic salt. What is a deci-normal solution? Give example.

2. Carbon dioxid and carbon monoxid—give formula and general properties of each and explain their toxic action when inhaled.

3. Give the chemical formula and general properties of plaster of paris. Explain the process of "setting."

4. Give general properties of and name antidote for phenol. Construct its graphic formula and show its relation to benzene.

5. Name the chemical constituents of gallstones and give in detail a reliable test for bile in the urine.

6. Detail two reliable methods for detecting albumen in urine and one method for the quantitative estimation of the same.

7. Give in full one test for the presence of sugar in the urine.

8. How is ferric hydrate prepared and for what is it principally used in medicine?

9. Describe subnitrate of bismuth and explain the dark color of the stools resulting from its administration.

10. To what class of chemical substance does glycerin belong?

Book Reviews.

FEVER. ITS THERMOTAXIS AND METABOLISM. By Isaac Ott, A.M., M.D., Professor of Physiology, Medico-Chirurgical College, Philadelphia; Member of The American Physiological Society; Ex-President of The American Neurological Association; Consulting Neurologist Norristown Asylum, Member of The Deutsche Medicinischen Gesellschaft of New York; Member of Vereinigung Alter Deutschen Studenten in Amerika; American Society for Pharmacology and Experimental Therapeutics; Society for Experimental Biology and Medicine; Member of The American Association for the Advancement of Science; Corresponding Member of Atlanta Academy of Medicine; Member of The Philadelphia Medical Club, and Chemists' Club of New York, etc. 1914. New York: Paul B. Hoeber. Cloth, $1.50 net.

This monograph of some 160 pages consists of an embodiment and refinement of three lectures delivered to the Sophomore Class of The Medico-Chirurgical College. It deals essentially with the normal adjustment of the bodily temperature as influenced by metabolism. No more important factor engages the attention of the physician than temperature, therefore the conclusions drawn by the author, after more than 45 years of investigation, should interest the profession. In studying the phenomena of heat he used the three methods: (1) by the thermometer, (2) by the calorimeter, and (3) by the amount of oxygen absorbed and the amount of carbon dioxide eliminated. After going into those elements which regulate the heat of the body and describing in detail experiments for the proof of his deductions, he engages in a discussion of those agents which cause a variation in heat production, and finally into a detailed account of fever in man.

MEDICAL JURISPRUDENCE: A STATEMENT OF THE LAW OF FORENSIC MEDICINE. By Elmer D. Brothers, B.S., LL.B., Member of the Chicago Bar; Lecturer on Jurisprudence in the Medical and Dental Departments of the University of Illinois and in John Marshall Law School. St. Louis: C. V. Mosby Company. 1914. Cloth, $3 net.

This book concerns itself with law as it affects the doctor. It enters very thoroughly into the qualifications, conduct, etc., of the expert witness, the dying declaration, adverse statements in the presence of a party, statements by patients to physicians, evidence, privileged communications, the license, civil practice, etc. In fact, it covers the ground in those things which affect the status of the physician legally. Those contemplating the purchase of a book of this character will find in Brothers' Medical Jurisprudence all they could desire.

MARYLAND MEDICAL JOURNAL

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BALTIMORE, FEBRUARY, 1915

LAY PRESS PUBLICITY BY THE MEDICAL MAN.

THAT cities other than Baltimore have been or are inflicted with lay-press advertising by the medical man is attested by an article in the November issue of the *Medical Review of Reviews.* In fact, the problem has become so pressing in New York that the Medical Society of the County of New York appointed a special committee to investigate the evil. Some of the conclusions of this committee as published in the *New York State Medical Journal* are pertinent to the situation which previously existed in our own city. This committee sums up the situation accordingly. Your Board of Censors has observed with regret the rapidly-increasing number of publications in the lay press concerning the professional activities of many prominent members of the Society. It has been found that the articles appear in the daily papers, in the weekly illustrated papers and in the monthly magazines. Some are written by the physician himself, and others by a lay author whose name is mentioned. In the majority of instances it is difficult to decide whether the article is written by the physician or by someone else. Some have no illustrations, the majority have the physician's picture, and some are profusely illustrated, showing the physician at work in the office, laboratory, clinic or hospital.

In the Principles of Medical Ethics as outlined by the American Medical Association the following abstract occurs: "It is unprofessional to procure patients by indirect advertisement, or by furnishing or inspiring newspaper or magazine comments concerning cases in which the physician has been or is concerned." All other self-laudations defy the traditions and lower the tone of any profession, and so are intolerable. It is not the intention to convey the idea that every article such as is being considered is an advertisement written by the physician for the purpose of increasing his practice. There are doubtless some which appear without the knowledge or consent of the man described. The newspaper editor, naturally anxious and probably morally bound to shield the espoused physician, cannot be expected to make the statement that a published article is a self-laudation accepted only because the contents make a good copy, and not a literary effort of the editorial staff.

The public demands information on the progress in medical science; it has a right to do so, but any information which is given the public should be the substantiated truth, and not the vaporings of an enthusiast who may awaken false hope and by the unsuccessful outcome of his efforts lower the confidence of the public in the profession.

Some months back Baltimore's profession was passing through the throes of a like infringement of the best traditions of her medical profession by some of the most prominent members of the profession. As in New York, the State Society undertook an investigation and came to practically the same conclusions, to wit:

That the medical profession fully appreciates the desire of the public for information on medical and surgical advances. It was therefore resolved when members gave information to the press, it should be done in an impersonal manner.

To the credit of Maryland's profession, the suggestion of the State Society has been, so far as we are aware, without violation, and an intolerable condition rectified.

Medical Items.

Dr. William Fulford Sappington of Webster Mills, Pa., has removed to Hancock, Md., where he has opened offices.

Prof. Randolph Winslow, who has been confined to his home with an attack of grip, has recovered and resumed his duties. Professor Winslow is professor of surgery at the University of Maryland.

A Physicians' Civic Club has been organized in Baltimore by Dr. William T. Watson, with an initial membership of 25.

The James Buchanan Brady Urological Institute, established through the benefaction of the millionaire of that name, was informally opened Thursday, January 21. The new institute forms an impressive addition to the Johns Hopkins Hospital group of buildings. The institute was established by Mr. Brady, who is known throughout the country as "Diamond Jim" Brady, as a monument of gratitude for the work done in restoring him to health by Dr. Hugh H. Young.

Dr. J. McPherson Scott, Hagerstown, secretary of the State Board of Medical Examiners, has announced that of the 41 who took the examinations December 9 to 11, in Baltimore, the following passed and were licensed to practice medicine and surgery in Maryland: William B. Blanchard, Wilford A. H. Councill, Crawford H. Douthist, James Earle Dull, Louis D. Englerth, John S. Fenby, Alexander J. Gilliis, Harry C. Grant, Percy P. Hartt, Edward Jelks, Peter L. Keough, Erwin E. Mayer, Winthrop E. McGinley, Louis D. Minsk, Fuller Nance, Stacy Taylor Noland, Nicholas William Pinto, James Cary Parran, Henry S. Purnell, John L. Redmond, Samuel Alexander Rosse, John Holt Sewell, John F. Smith, Vernon S. Wilkinson, Austin H. Wood and Ira M. Zimmerman.

Dr. C. Hampson Jones, Assistant Commissioner of Health, who has been a patient at the Church Home and Infirmary, has sufficiently recovered to resume his duties at the Health Department.

At the January meeting of the University of Maryland Medical Society, held at the Hospital amphitheater, January 20, Dr. Albert J. Underhill read a most interesting paper, entitled "Observations on the Blood Urea Content."

The home of Dr. J. Carl Smith, Ellerslie was seriously damaged by fire December 13.

A subscription dance and card party was given at the Emerson Hotel on Friday evening, January 29, for the benefit of the new South Baltimore Eye, Ear, Nose and Throat Hospital.

A letter was recently received by Caleb C. Magruder, Clerk of the Court of Appeals, from his son, Dr. Ernest P. Magruder, who is surgeon in command of the third American Red Cross unit in Servia. He sailed from New York on the steamer Finland on November 21, landed at Patros, Greece, and sailed thence to Saloniki on the Greek steamer Erisos, expecting to go to Nish or to Uskup, Servia.

The letter from Dr. Magruder was written at Athens on December 12, just as he was about to start for Saloniki. His trip, he says, was beautiful and impressive, but he was shocked when he arrived at Corinth to find what was once the richest city in the world nothing more than a poverty-stricken country village.

The Queen of Greece sent word that she wished to receive the Americans at noon on the day after their arrival at Athens, and when they called she asked many questions about the Red Cross and hospital work, seeming much interested in what she was told.

"I have spent all my time since I have been here," writes Dr. Magruder, "in getting together some additional medical and surgical supplies, of which we are in great need if we expect to do efficient work. They know nothing of American business methods here, and one spends hours in doing what should require but a few minutes at most to accomplish. It looks now as if we shall be located at Uskup, Servia, and not Nish, as we at first thought, or this may be changed. I hope to know definitely when we reach Saloniki, where the actual site of our hospital will be, although I may not be able to write from that point, as the Servian Minister tells me they are dreadfully in need of us as soon as it is possible for us to get there. He tells me that he has arranged for a special train to rush us ahead from Saloniki as soon as we reach there."

MARRIAGES.

Katherine Tallman Westervelt, R. N., class of 1911, Johns Hopkins Hospital Training School for Nurses, to Henry Cutler Low, at Brooklyn, N. Y., October 2, 1914.

Katherine Staples, R. N., class of 1913, Johns Hopkins Hospital Training School for Nurses, to Dr. Oswald Lowsley, at Troy, N. Y., August 20, 1914.

PHILLIPS'

Phospho-Muriate of Quinine

COMP.

An Aromatic Syrup Containing Phosphoric Acid and Phosphates of Potash, Magnesia, Lime and Iron with Muriate of Quinine and Strychnine

A Reliable Tonic and Reconstructive

Free from Alcohol

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Made from Fine Selected Beans of Cacao Theobroma

A Delicious Food Beverage
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"THE COCOA WITH A RICH CHOCOLATE FLAVOR"

The tablets can be gently slipped from the thread if you prefer.

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in order to release for use one of our

Threaded Mercury Bichloride Tablets

will always prevent their accidental internal use because the only medicinal tablets "on a string" are

SHARP & DOHME'S
Threaded Mercury Bichloride Tablets

Mercury bichloride, 7 gr. } Accurate, perfectly soluble, blue,
Citric acid, $3\frac{48}{100}$ gr. } clover leaf shape, "Poison" on each.

In bottles of 25 only—each tablet attached by a thread to the other 24. The thread is a perpetual accident insurance against bichloride poisoning. It "flags the train of thought" and suggests poison.

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Edna Earle, of the nursing staff of the Maryland General Hospital, to Thomas Gemmill, at the Presbyterian church, Ellicott City, Md., November 21, 1914.

Thomas Brooks, M.D., University of Maryland Medical School, 1910, to Miss Dolores Maria Mason, both of Santiago, Cuba, at Santiago, December 9, 1914.

Nathan P. Sears, M.D., Johns Hopkins Medical School, 1912, of Syracuse, N. Y., to Miss Emily C. Rivers of Baltimore, Md., at Baltimore, January 4, 1915. Dr. Sears is connected with the Lakeside Hospital, Cleveland, Ohio.

BIRTHS.

Recently, to William E. McClanahan, M.D., University of Maryland Medical School, 1902, and Mrs. McClanahan, of 1619 S. Clinton street, Baltimore, Md., a daughter, Marjorie Mercedes.

DEATHS.

Thomas Henry Moore, M.D., Maryland Medical College, Baltimore, 1912, died at his home in Williamsett, Mass., October 21, 1914, aged 26 years.

John J. Chambers, M.D., College of Physicians and Surgeons, 1884, formerly of Portland, Ore., but for 14 years a practitioner of Nome, Alaska, died in the Morningside Sanitarium, Portland, Ore., December 5, 1914, aged 55 years.

Edward W. Myers, M.D., University of Maryland, 1862, a pioneer practitioner of Leavenworth, Kans., died at his home in Kansas City, Mo., December 14, 1914, aged 77 years.

Thomas Wilfred Flood, M.D., Baltimore University School of Medicine, 1902, died at his home in Haverhill, Mass., December 16, 1914, from typhoid fever, aged 31 years.

Clinton Wagner, M.D., University of Maryland, 1850; surgeon-in-chief of the Second Divison of the Fifth Army Corps of the Army of the Potomac; prime mover in the establishment of several military hospitals, including the first floating hospital on Western waters; founder of the New York Laryngological Society and instrumental in the founding of the American Laryngological Society; inventor of many surgical instruments and author of voluminous literature relating to his specialty; died in Geneva, Switzerland, November 25, 1914, aged 77 years.

Mosheim S. Burgess, M.D., Maryland Medical College, 1907, formerly of Medford, Ore., died in his office in Wayne, W. Va., November 24, 1914, from the effects of a gunshot wound of the head, self-inflicted, aged 34 years.

William Ernest Walker, M.D., Baltimore College of Dental Surgery, 1889; University Medical College, Richmond, Va., 1900; an Associate Fellow of the American Medical Association and a prominent dentist and oral surgeon of New Orleans, died in the Hotel Dieu in that city, November 21, 1914, aged 46 years.

Charles W. Shreve, M.D., University of Maryland, 1858, for many years a practitioner of Dickerson, Md., died at the home of his son in Washington, D. C., November 24, 1914, from the effects of a fracture of the hip three months before, aged 80 years.

J. M. Sheppard, M.D., Baltimore Medical College, 1894, a member of the West Virginia Medical Association, was found frozen to death near his home at Falls Mills, Va., November 21, 1914.

Ralph H. Augur, M.D., Baltimore Medical College, 1909, a post-graduate worker in Johns Hopkins Hospital, was found dead in his office in Baltimore, November 27, 1914, aged 32 years.

John T. Digges, M.D., for many years one of the best-known physicans in Southern Maryland, died at his home near La Plata, Md., January 14, 1915, aged 73 years.

John Cronmiller, M.D., University of Maryland, 1857, of Laurel, Md., died January 1, 1915, at the University Hospital, Baltimore, after an illness of several weeks, aged 82 years.

Ralph Walsh, M.D., one of the best-known physicians of Washington, died at his home, the Mound, in Harford county, Md., January 15, 1915, after a lingering illness, aged 73 years.

Algernon Gray Smith, M.D., Physicians and Surgeons, '72, of Midland, Md., died at the home of his son in Cumberland, Md., January 11, 1915, from paralysis, aged 64 years.

William G. Wilson, M.D., University of Maryland, '52, of Shelbyville, Ill., died at his home in that city January 16, 1915, aged 87 years. Dr. Wilson had not been in active practice for some years.

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Reject < Cheap and Inefficient Substitutes
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THE MOST SUCCESSFUL TREATMENT OF MORPHINISM AND ALCOHOLISM TODAY.

Medical Review of Reviews.

THE history of mankind from the earliest dawn to the present day has been one long, incessant struggle against slavery, either actual bodily slavery, or spiritual and mental slavery. Centuries and centuries of struggle, in which millions of people lost their lives, were waged against tribal slavery, feudal slavery, oligarchical and monarchial slavery, and last but not least chattel slavery; and finally humanity has reached a semblance of liberty. There is one kind of slavery, however, that still holds its victims in an iron clutch as relentlessly and as mercilessly as ever before. In fact, on account of various factors in our civilization, that kind of slavery is more firmly entrenched than it was ever before; nay, its victims have of late years been increasing at an alarming rate.

We are referring, of course, to the slavery of the drug and alcohol habit. And the victims of the drug habit have up to very recently been the most pitiful of human beings, for the broad-minded and unbiased physician—and to him alone this article is addressed—will frankly admit that up to a few years ago there was practically no scientific treatment of the alcohol habit, the opium and morphine habit, and the cocaine habit. The private physician stood helpless before these cases, while the numerous sanatoria that flourished—the less said about them the better. A few of them conscientiously tried to help the patient, but their methods were crude and unscientific and—what is more important—inefficient. Most of them, however, were cold-blooded money-making affairs, whose sole purpose was to bleed the patient, and they bled him to the last farthing, and he was then sent away, often in a worse condition than when he entered. Very few patients improved in those sanitaria, and even the improvement was a temporary one, necessitating the patients' returning again and again, while many sank lower and lower, not a few ending their career in a suicide's grave.

This black, somber picture received a brighter, rosier hue when, a few years ago, Mr. Chas. B. Towns, a layman, gave to the medical profession, gratuitously, and without any expectation of reward, his treatment for alcoholism and the drug habit. This treatment received the unqualified endorsement of our foremost physicians and was fully explained (see below) by Prof. Alexander Lambert in *The Journal of the American Medical Association,* and by Prof. Richard C. Cabot in the Boston *Medical and Surgical Journal.*

* * * * * * *

"Five years ago Mr. Charles B. Towns of New York city informed me that he had a treatment by the use of which it was possible in about three days to remove the craving for morphine and cocaine and also for alcohol. After this desire for the narcotics was gone the patient would be able to remain free from the use of morphine, and if it was worth while to the patient it was possible for him to abstain from the use of cocaine and alcohol. Mr. Towns, not being a physician, was not bound to tell me the ingredients of this treatment. I begged him to publish it and to put it on an ethical basis, as otherwise I could not use it, but at that time it did not seem expedient for him to do so. Recently

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Thoroughly modern and completely equipped. Courteous service. Bathrooms with hot and cold, fresh and sea water attachment. Orchestra. Extensive porches overlooking the Boardwalk. Always open. Golf privileges.

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PAIN

--- however severe or wherever located — can be quickly and satisfactorily controlled by

PHENALGIN

Prompt and efficient in action, this dependable analgesic not only affords the anodyne effect desired, but without deranging digestion, locking up the secretions, producing constipation, or inducing a drug habit.

Thus it is that Phenalgin has supplanted opium and its derivatives for the relief of **Headache, Rheumatism, Gout, La Grippe, Lumbago, Neuralgia, Disorders of the Female and painful conditions generally.**

To countless physicians Phenalgin is "the one dependable analgesic—the logical supplanter of opium."

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Samples and interesting information on request.

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Lungs, Glands, Bones or Joints will be greatly benefited by the use of

PROTONUCLEIN BETA

Combining the nucleins of the spleen with Protonuclein

Attention must be paid to the marked results obtained abroad by the use of the spleen in tubercular cases.

We have combined this action of the spleen with the well-known reconstructive action of Protonuclein, meeting the modern theory of building up the body to combat Tuberculosis.

See that your prescription reads:

℞ PROTONUCLEIN BETA CUBES, GR. V.
No. 60

Sig. 2 cubes 3 times a day, one hour after meals. Chew the cubes.

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he has made the treatment known in all its details to the Opium Congress at Shanghai, and on his return from China he has given me the full details of the treatment, and I have been using it in Bellevue Hospital during the last two months.

"While the treatment was still unknown to me, and before I used it, I watched Mr. Towns treat various patients addicted to morphine, cocaine and alcohol, and found that the claims he made for the treatment were true. I have, therefore, watched patients who ceased the use of their drug five years ago and have not returned to it, and recently I have myself carried out the treatment indicated below."

Another article on the same subject by the same author appeared in the same journal for February 18, 1911, and still another in the same publication for June 21, 1913. The last-named article contains the latest development of the treatment, which we will, for the benefit of the profession, reproduce here. One of the essential factors of the treatment is a mixture of belladonna, xanthoxylum and hyoscyamus which has the following composition:

		Gm. or c.c.
R	Tincture belladonnæ.....	62 ℥ij
	Fluidextracti xanthoxyli.....	
	Fluid extractihyoscyami..... aa	31 ℥j

In making the mixture of belladonna, hyoscyamus and xanthoxylum, a 15 per cent. tincture of the belladonna must be used, or an equivalent amount administered if a weaker tincture of belladonna is used. If this is not done the craving for the drug often remains as a nagging longing, and the obliteration of the craving is incomplete. It is also the author's personal experience that unless the mixture is pushed to the beginning physiologic tolerance of the belladonna, as shown by dry throat, dilated pupils or even a flushing and a rash, or the beginning incisive voice of the commencing belladonna hallucinations, though the last named is to be avoided if possible, the desired results are not obtained. The converse is true that the desired results are obtained even if only one, two or three drops of this belladonna mixture can be tolerated by the patient every hour. It is further essential that this belladonna mixture should be given persistently in small doses, and not by the teaspoonful, three times a day.

It is also absolutely essential that the morphine patient before starting in the treatment should have a thorough cathartic action before the belladonna treatment is begun. At this time an enema is not sufficient, and unless such cathartic action has been obtained, patients are very sure later to be troubled with persistent vomiting. Further, though not essential, it is wiser to give three-fourths of the total twenty-four-hour dose instead of two-thirds as the initial dose of morphine. The patients thus go through their first two periods without any distress, and they do not begin to have the symptoms of discomfort until the third dose of morphine begins to wear off. If but little morphine is given in the beginning dose, and one halves it at the second dose and halves it again at the third dose, owing to the insufficiency in the beginning,

The reason for

Constipation of Infants

may often be readily traced to imperfect digestion of protein or fat, to a deficiency of total solids in the diet, to a lack of energy, or to a diet containing starchy substances. While this condition is not necessarily a serious one, a natural elimination with soft, smooth stools of a good character is much to be desired, and has no little bearing on the general health of the infant.

The prompt and favorable results following the use of Mellin's Food in constipation is common knowledge to a vast number of medical men, but to physicians who are not familiar with the application of Mellin's Food to correct these errors of diet, we will send, if desired, suggestions which will be found very helpful.

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NOTARY PUBLIC

608

PROFESSIONAL BUILDING

the patient is not really comfortable at any time and has a nagging desire for more.

The detailed treatment for morphinism is given by Dr. Lambert as follows, and we give it here in his own words:

A patient addicted to morphine is given five compound cathartic pills and five grains of blue mass, and six hours later, if these have not acted, they are followed by a saline; after three or four abundant movements of the bowels from these cathartics the patient is given, in his habitual way, by mouth or by hypodermic, in three divided doses at half-hour intervals, two-thirds or three-fourths of the total daily twenty-four-hour dose of morphine or opium to which he has been accustomed. The physician should observe carefully after the second dose has been given as the amount then equals either four-ninths or one-half the total twenty-four-hour dose. A few patients cannot comfortably take more than this amount. Six drops of the belladonna mixture are given in capsules at the same time as the morphine. This belladonna mixture in doses of six drops (and by drops I do not mean minims; I mean drops dropped from an ordinary medicine dropper, which is about half a minim dose) is given every hour for six hours. At the end of six hours the dosage is increased two drops. The belladonna mixture is continued every hour of the day and every hour of the night continuously throughout the treatment, increasing two drops every six hours, until sixteen drops are taken, when it is continued at this dosage; it is diminished or discontinued at any time if the patient shows belladonna symptoms, such as dilated pupils, dry throat or redness of the skin, or the peculiar and incisive and insistent voice, and insistence on one or two ideas. It is begun again at reduced dosage after these symptoms have subsided. If the patient has an unusual sensitiveness to belladonna it will usually show itself in the first six or eight hours, and the hourly dosage can be cut down to from two to four drops and raised by one drop every six hours. If, on the other hand, even sixteen drops persisted in for twelve consecutive hours do not give dryness of the throat, the dosage should be raised to eighteen or twenty every hour until the dryness occurs and then the amount reduced.

At the tenth hour after the initial dose of morphine is given the patient is again given five compound cathartic pills and five grains of blue mass. These should act in six or eight hours after they have been taken. If they do not act at this time, some vigorous saline is given, and when they have acted thoroughly the second dose of morphine is given, which is usually about the eighteenth hour. This should be one-half the original dose, that is, one-third or three-eighths of the original twenty-four-hour daily dose. The belladonna mixture is still continued, and ten hours after the second dose of morphine has been given, that is, about the twenty-eighth hour, five compound cathartic pills are again given and five grains of blue mass, these again, if necessary, followed by a saline seven or eight hours later. After these have thoroughly acted at about the thirty-sixth hour, the third dose of morphine is given, which is one-sixth or three-sixteenths of the original dose. This is usually the last dose of morphine that is necessary. Again, ten hours after the third dose of morphine, that is, the forty-sixth hour, the five compound cathartic pills and five grains of blue mass are again given, followed seven or eight hours afterward by a saline, and one expects at this time to see the billious green stool

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hold a definite place in cardiac therapy as
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in functional diseases of the stomach has no superior as
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appear. When this appears, after the bowels have moved thoroughly, about eighteen hours after the third dose of morphine, about the fifty-sixth hour of treatment, two ounces of castor oil are given to clear out thoroughly the intestinal tract. Sometimes it is necessary to continue the belladonna mixture over one or two more cathartic periods before giving the oil. During this last period when the bowels are moving from the compound cathartic pills and before the oil is given, the patients have their most uncomfortable time. Their nervousness and discomfort can be controlled usually by codein, which can be given hypodermically in five-grain doses, and repeated if necessary, or some form of the valerianates may help them. About the thirtieth hour of treatment these patients should be stimulated with strychnin or digitalis, or both, every four to six hours.

Some patients cannot tolerate codein and break out into an urticarial rash or a fine red punctuate rash or swelling and burning of the skin. In these patients relief can be obtained by dionin, which seems about twice as strong as codein in its power to relieve nervousness and the feeling of distress. It should be given, therefore, in doses of about two or three grains or less. Codein or dionin should be cut off as soon as possible after the castor oil has acted. It may be given during the next succeeding twenty-four hours if necessary, but if patients are for any reason taking codein for forty-eight hours after they are through their treatment, they will usually persist in doing so, and must be broken from this narcotic or they will from this return quickly to their morphine or heroin.

The withdrawal pains or pain in the joints and aching in the bones and muscles can sometimes be relieved by hypodermics of some form of ergot and strychnin, sometimes by massage, sometimes by sodium salicylate, sometimes by a salicylic compound combined with some of the coal-tar products, such as antipyrin, phenacetin or pyramidon; they can always be eased up by codein or dionin. The addition of codein to these coal-tar products increases their analgesic effect. These patients have been in the habit of referring all their discomfort and distress to the lack of morphine and have consequently drifted into the habit of referring everything to the lack of it. For two or three days after they are off their drug any indiscretion in eating, or any attempt at too much physical exertion, will bring a recurrence of their withdrawal symptoms. This is simply due to exhaustion or to indigestion, and if treated as such quickly disappears without any narcotic. Insomnia is often a troublesome symptom after the patients are off their drug. This may have to be treated in some patients with doses of bromids, in others by chloral or by other various hypnotics. Veronal has, in my hands, given so much depression and produced so many bad after-effects that it should be avoided. The best hypnotic is muscular fatigue, and these patients should begin to exercise regularly and be built up physically as soon as their condition permits. Usually this is within a week after they are off their drug.

(Continued in March Number.)

Drug Addicts
Alcoholics
Neurasthenics

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For the Treatment of

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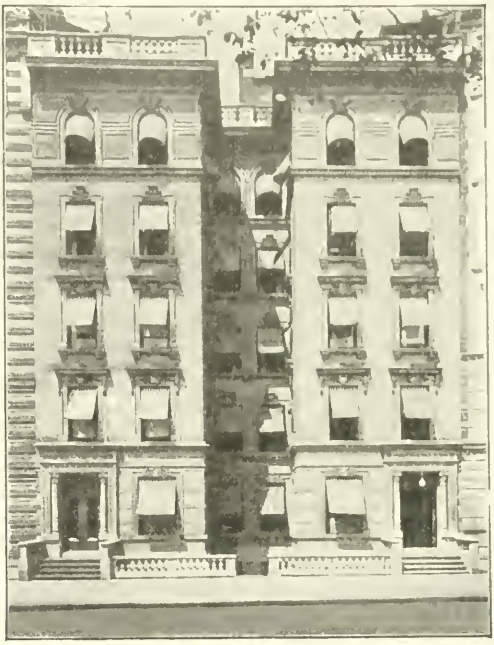

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PRIVACY is a feature of this hospital; we are not interested in the social position of a patient; we do not group or mass our patients together; each is treated individually. Patients are separated and not permitted to invade the privacy of each other.

THE TOWNS METHOD has been fully explained in articles appearing in the Journal of the American Medical Association, and reprints of these and articles from other publications, together with a booklet containing full information as to the treatment, duration, terms, etc., will be mailed on application.

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Editorial Comment.

THE ETIOLOGY OF PELLAGRA

"Although pellagra has been known and studied for nearly two centuries," says *The Journal of the American Medical Association* in its issue of September 26, "not only is its essential cause unknown, but the broad question whether it is to be classed as a dietary or a communicable (contagious or infectious) disease has never been definitely determined. The spoiled-maize theory has for many years been the favored theory abroad, but its correctness has, for various reasons, been questioned by many. In this country there has arisen, both in the lay and in the medical mind, the opinion that pellagra is to be classed among the infectious diseases. This view has received important support, first, from the Illinois Pellagra Commission and, more recently, from the Thompson-McFadden Commission (Siler, Garrison and MacNeal). *The Journal* calls attention to a recent issue of the United States Public Health Reports, in which Goldberger gives a summary of certain work now being done by the United States Public Health Service on the study of pellagra, and advances some most suggestive facts which do not in any way support the infection theory, but strongly point to the belief that pellagra is a disease essentially of dietary origin; that it is brought about in some such way as, for example, by the absence from the diet of essential "vitamins," or possibly, as is suggested by work of Myers and Voegtlin, on the presence in vegetable foods of excessive amounts of a substance such as soluble aluminum salts.

PUBLIC HEALTH IN INDIANA

The Journal of the American Medical Association for September 26, editorially compliments health administration in Indiana, which it states for a long time past has been vigorous and energetic. "It has also been unique, peculiarly up-to-date and popular in its methods of attracting attention and affording instruction," says *The Journal*. "The latest activity of the health forces of the State is thoroughly characteristic. Governor Ralston issued a proclamation designating Friday, Oct. 2, 1914, as Disease Prevention Day. He urged the cities and towns throughout the State to make special arrangements for appropriate exercises, emphasizing the importance of public health, and the joint responsibility of all citizens therefor in order to inspire in them a desire to co-operate in all sane efforts for the prevention of physical diseases. The State Board of Health prepared a special bulletin containing a copy of the Governor's proclamation and suggestions for the celebration of Disease Prevention Day in towns of Indiana. Some of these suggestions are terse and apt and deserve to be circulated.

"Get up a public-health procession. In cities the mayor should head the procession; in towns the town board of trustees, the town board of health under the law, should lead. There should be a brass band; drums and trumpets should be used; music is necessary for a procession; school girls dressed in white bearing banners with health mottoes, boys in white or otherwise neatly dressed carrying banners with health mottoes. Where there are high schools, the pupils should try to present some original idea representing the importance of disease prevention.

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Intestinal Toxemia.

THE investigations of Metchnikoff and Schmidt, together with the later studies of Lane, Jordan and many others, have lain such emphasis on the evils resulting from intestinal stasis that it is at last recognized that no small proportion of the diseases afflicting the human family are directly attributable to faulty elimination of the intestinal accumulations in the lower bowel. For a long time, to be sure, the evils of chronic constipation have been realized, but it is doubtful if, until Lane began to speak of the large intestine as the "cesspool of the human body," the dangers of intestinal putrefaction were fully appreciated.

It is hardly probable that Lane's radical treatment of "short-circuiting" the bowel—the removal of three to eight feet of intestine—will ever be popular, and simpler measures will unquestionably hold a definite place in the management of intestinal statis for some time to come.

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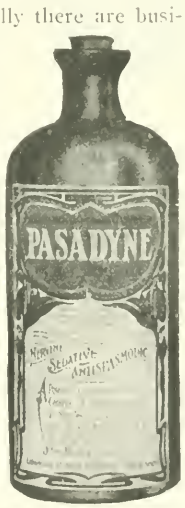

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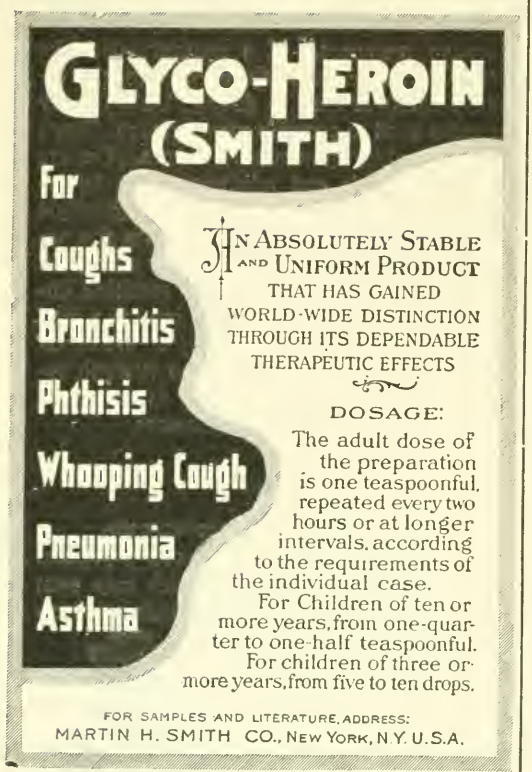
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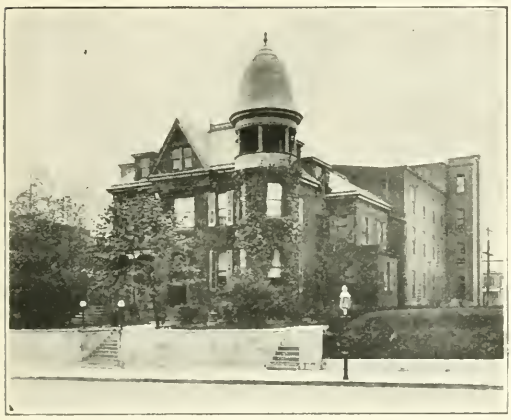

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